STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX
Petitioner **File No. 87282-001**

v

MEGA Life and Health Insurance Company
Respondent
_____/

Issued and entered
This 3rd day of March 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On January 18, 2008, **XXXXX**, authorized representative of **XXXXX** (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Services under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The matter was accepted on January 25, 2008.

MEGA Life and Health Insurance Company (MEGA) was notified of the external review and was asked to submit the information used in making its adverse determination. MEGA provided the information and documents on January 24, 2008.

The issue here can be decided by applying the terms of the certificate of coverage (the certificate), the contract defining the Petitioner's health care benefits. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

The Petitioner has a one-year, limited benefit, non-renewable student insurance policy through the American University of Antigua that is underwritten by the MEGA Life and Health Insurance Company.

The Petitioner sustained a serious fracture of his left humerus on May 22, 2007, in Antigua and was treated at the hospital. When the break did not heal properly, the Petitioner came to Michigan for treatment. Surgery was performed June 5, 2007, at **XXXXX**. The hospital, the anesthesiologist, and the surgeon were not in MEGA's provider network. When claims were submitted to MEGA, they were paid at the out-of-network benefit level, leaving the Petitioner responsible for a balance of $20,667.65.

The Petitioner appealed. MEGA reviewed the claims but affirmed its decision and sent a final adverse determination to the Petitioner dated January 10, 2008.

III
ISSUE

Is MEGA required to pay more for the Petitioner's surgery on June 5, 2007?

IV
ANALYSIS

Petitioner's Argument

The Petitioner says he returned to the United States for medical advice and treatment after his fractured left arm was improperly set at the hospital in Antigua. He says he contacted the Beech Street network (the preferred provider network for his student insurance plan) and was given authorization to treat at **XXXXX**. He also says Beech Street told him that his policy would cover students who leave Antigua for treatment in the United States at 80% of the preferred allowance up to $5,000.00 and 100% up to $250,000.00.

The Petitioner believes he had a medical emergency, that his health was in jeopardy

because the injury had created serious impairment of bodily functions, and his care should be covered as such. The Petitioner also believes that MEGA's usual and customary charges are too low and that MEGA should pay more of the billed charges.

The Petitioner believes MEGA should provide coverage for his treatment and surgery at **XXXXX** Hospital at the network level of benefits.

MEGA's Argument

MEGA says coverage is based on the network status of a provider. Providers in MEGA's network have agreed to provide specific medical care at negotiated fees. MEGA pays 80% of those fees up to $5,000.00 and then 100% up to $250,000.00.

However, non-preferred or out-of-network providers have not agreed to a pre-arranged fee, and MEGA's payment to them is based on 60% of the "usual and customary" fee for the service received. When services are received from out-of-network providers, there may be significant out-of-pocket costs because insureds, like the Petitioner, could be responsible for billed charges in excess of the usual and customary fee as well as any applicable deductible and coinsurance.

MEGA says that **XXXXX** Hospital, the surgeon, and the anesthesiologist were all out-of-network providers. Therefore payments were made at 60% of MEGA's usual and customary charge for their services.

"Usual and customary charge" is defined in the Petitioner's certificate to mean

> a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality of the Policyholder. No payment will be made under this policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges.

MEGA asserts that the Petitioner's claims for service from out-of-network providers were processed correctly according to certificate provisions.

Commissioner's Review

Using information from the explanation of benefits forms and other material in the record, the

Commissioner has determined that the Petitioner's claims were paid as shown here:

Provider	Provider's Charge for Services	MEGA's U&C Charge for Services	Applied to $250 Deductible	Paid by MEGA (60% of U&C after any deductible)	Petitioner's Responsibility (40% of U&C Coinsurance + Deductible + Balance of Provider's Charge)
Hospital	$ 26,105.85	$ 11,237.00		$ 6,742.20	$ 19,363.65
Anesthesiologist	1,575.00	1,575.00		945.00	630.00
Surgeon	1,400.00	1,400.00	$ 190.00	726.00	674.00
Totals	$ 29,080.85	$ 14,212.00		$ 8,413.20	$ 20,667.65

There is no dispute in this case that all the providers were out-of-network. While the Petitioner's plan covers out-of-network services, those services are subject to a higher coinsurance than network services (40% instead of 20%). Because out-of-network providers have not agreed to accept MEGA's pre-arranged fee as payment in full for their services, they are free to bill the Petitioner for any balance beyond what MEGA pays, as they apparently have done in this case. The Petitioner's certificate (page 6) warns about this:

> "Out of Network" providers have not agreed to any prearranged fee schedules. Insureds may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are the Insured's responsibility.

After reviewing the record, the Commissioner finds that MEGA processed the Petitioner's claims for the surgery on June 5, 2007, according to the terms and conditions of the certificate. MEGA paid 60% of its usual and customary fee for the services the Petitioner received from out-of-network providers. While the Petitioner believes MEGA's usual and customary charge for the services he received was too low, the Commissioner has no regulatory authority over the amount an insurance carrier chooses to reimburse for covered services.

The Petitioner further contends that the surgery was an emergency and therefore should be covered at the preferred provider level as the certificate requires. However, no medical

documentation was provided to support that contention, and the Commissioner cannot find from the Petitioner's own recitation of events, that surgery in the United States 14 days after the accident in Antigua rose to the level of a medical emergency as that term is defined in the certificate (page 11).

There is also an assertion by the Petitioner that Beech Street, the preferred provider network, approved the surgery in advance at the preferred provider level. MEGA says that Beech Street is not authorized to approve surgery or discuss benefit levels and that it (MEGA) received no contact from the Petitioner before June 5, 2007, the day of the surgery. However, even if the Patient's Right to Independent Review Act had a process for resolving disputes about alleged oral statements, the Commissioner lacks the authority to order relief based on doctrines such as estoppel.

It is unfortunate if the Petitioner did not understand the extent of his liability before he received services from an out-of-network provider. Nevertheless, under the facts of this case, the Commissioner finds that MEGA paid the Petitioner's claims according to the terms and conditions of his coverage.

V
ORDER

The Commissioner upholds MEGA's adverse determination of January 10, 2008. MEGA is not required to pay more for the Petitioner's services on June 5, 2007.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the Circuit Court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.